



City of Renton

Human Services Division

Housing Repair Assistance Program

Home Assessment Form

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Date Performed: _____

Performed by: _____

Name:	Photo of home? No Yes More than one story? No Yes
Address: Zip:	Mobile Home? No Yes
Hm Phone: Cell Phone:	Condominium? No Yes (If yes, start on page 3 Front Entry)

Exterior

<u>Exterior Siding:</u>	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Type	Aluminum <input type="checkbox"/> Vinyl <input type="checkbox"/> Wood <input type="checkbox"/> Other <input type="checkbox"/> Cement Board <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Trim:</u>	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Type	Aluminum <input type="checkbox"/> Vinyl <input type="checkbox"/> Wood <input type="checkbox"/> Other <input type="checkbox"/> Cement Board <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Windows:</u>	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Frame Type	Aluminum <input type="checkbox"/> Vinyl <input type="checkbox"/> Wood <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Broken or cracked glass pane	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?
Glazing Type	Single Pane <input type="checkbox"/> Double Pane <input type="checkbox"/> Grid <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Condition of sealing and/or caulking.	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?



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<u>Skylights:</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to roof.)	Work Needed	Health or Safety Issue	Comments, Description, Details
Number & Condition	Number	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Material	Glass <input type="checkbox"/> Plastic <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Type	Flush mount <input type="checkbox"/> Curb Mount <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Roof:</u>	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Roof pitch?	<input type="checkbox"/> 0-6 <input type="checkbox"/> 7-12	-----	-----	
Roofing Material	Torch Down <input type="checkbox"/> Composition <input type="checkbox"/> Hot Tar <input type="checkbox"/> Shake <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gutters <input type="checkbox"/> Yes <input type="checkbox"/> No Color _____	Metal <input type="checkbox"/> Wood <input type="checkbox"/> Plastic <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Downspouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chimney	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Evidence of interior leaking	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Interior location -
<u>Crawl Space</u> <input type="checkbox"/> <u>Slab</u> <input type="checkbox"/> <u>Basement</u> <input type="checkbox"/>	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Dry N/A <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vapor barrier N/A <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	



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Evidence of pests N/A <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Garage <input type="checkbox"/> or Car Port <input type="checkbox"/>	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Attached to house	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Front Entry:	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Steps	<input type="checkbox"/> Yes <input type="checkbox"/> No # of steps_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Handrails	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ramp	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Non-skid?
Door closes securely	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Weather stripping	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dead Bolt	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Finish of existing lockset -
Security Light	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Second Entry:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Work Needed	Health or Safety Issue	Comments, Description, Details
Steps	<input type="checkbox"/> Yes <input type="checkbox"/> No # of steps_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Handrails	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ramp	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Non-skid?



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<input type="checkbox"/> Swing or Sliding door closes securely	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Weather stripping	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dead Bolt N/A <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Finish of existing lockset -
Security Light	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Interior

<u>Smoke Alarms:</u>	Existing	Needed	Health or Safety Issue	Comments, Description, Details
Living Room	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Each Bedroom	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hallway outside bedrooms	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Utility Room	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Basement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Primary Bathroom:</u>	Existing	Work Needed	Health or Safety Issue	Comments, Description, Details
Grab Bars - toilet	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Grab Bars – Tub/Shower	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Exhaust Fan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	



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Sink supply lines, shutoff valves and waste lines.	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sink Faucet	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tub/shower supply lines and waste lines.	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tub faucet(s), spout & or shower neck and head.	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Toilet, toilet supply line and shutoff valve.	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Toilet tank & flushing mechanism	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Caulking around tub/shower.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Second Bathroom: <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, go to Kitchen)	Existing	Work Needed	Health or Safety Issue	Comments, Description, Details
Grab Bars – toilet	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Grab Bars - Tub	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Exhaust Fan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sink supply lines, shutoff valves and waste lines.	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sink Faucet	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tub/shower supply lines and waste lines.	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	



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Tub faucet(s), spout & or shower neck and head.	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Toilet, toilet supply line and shutoff valve.	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Toilet tank & flushing mechanism	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Caulking around tub/shower.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Kitchen:</u>	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Sink supply lines, shutoff valves and waste lines.	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sink Faucet	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Garbage disposal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Removal needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Water Supply</u>	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Main shut off at house?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	location:
Water Pressure	_____PSI	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Universal Plumbing Code & the City require a pressure-reducing valve if pressure is above 80PSI.
<u>Hot Water Tank:</u> Circle one →	Electric Gas Other	Work Needed	Health or Safety Issue	Comments, Description, Details
Years in service	age _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	location:
Pressure relief valve installed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pressure relief valve vented to the outside	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	



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Earthquake straps	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Leased	<input type="checkbox"/> Yes <input type="checkbox"/> No	-----	-----	
<u>Heating System:</u>	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Fuel	Gas <input type="checkbox"/> Fuel Oil <input type="checkbox"/> Electric <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Working OK	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Type	Forced Air <input type="checkbox"/> Wall <input type="checkbox"/> Baseboard <input type="checkbox"/> Other <input type="checkbox"/> Free Standing <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Years in service	age _____	-----	-----	
If air filters exist are they easy to change? NA <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Needs Replacing? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Demonstrated filter removal and replacement? NA <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Size of Filters		
<u>Carbon Monoxide Alarm:</u>	Existing	Needed	Health or Safety Issue	Comments, Description, Details
-----	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Installation location:
<u>Electrical:</u>	-----	Work Needed	Health or Safety Issue	Comments, Description, Details
Outlets Working?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Switches Working?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Panel	Manu-facturer:	Amp. Capacity:	Breakers or Fuses (circle one)	